Medical Direction and Practice Board
21-Jun-06
Minutes

In Attendance
Members: Steve Diaz, David Ettinger, Eliot Smith, Paul Liebow, Kevin Kendall, Matt Sholl
Staff: Dawn Kinney
Guests: Jonnathan Busko, Norm Dinerman, Julie Ontengco, Paul Marcolini, David White, Jeff Regis, Rhonda Chase, Joanne LeBrun, Joe LaHood, Robin Overlock, Warren Waltz, Rick Petrie (Ops Rep), Ginny Brockway, Dan Palladino, Tim Beals (Board Rep), Dan Batsie (Ed Rep), Alan Azarra

Topic	Discussion	Action(s)
1) Minutes from May 2006	No discussion	Move to accept by Ettinger, Second by Smith, Unanimous approval
2) Legislative, Budget, and EMStar Updates	Diaz gave a brief update in the absence of Bradshaw who is in Washington DC. There is no news on legislative and budget at this time, and the board of MEMS is beginning to work on EMStar and trying to figure out their approach	No action
3) Annual Planning	We selected some annual goals: 1) Cardiac Care which may include a STEMI protocol, addresses the issue of diversion, 12 lead training-- this lives in our cardiac advisory committee; 2) Completion of PIFT and then began work on tackling the issue of PIFT with blood products; 3) EMD protocols and QA; 4) Protocol Revision; Finalize OLMC piece and get it up and running in a web-based format; 5) Continue to investigate and be open to all endavors that impact EMS; 6) Look at an evidence-based medicine review for all articles pertinent to EMS in the last year; 7) Respond to and position/partner with others to respond to the Institute of Medicine 2006 report; 8) Defining our role in a pandemic response; 9) Construct an intrafacility document that would be aimed at an FAQ type of function, and perhaps is a protocol that may fit in the Brown Section.	We will adopt these as our goals and carry them throughout the year. On the ninth point, asked for Education and/or Operations to discuss this and come to the MDPB with the questions/issues that need to be addressed including which provider levels to address.

4) PCA and epidurals	Diaz had a query this last month regarding the PCA portion of PIFT and whether it included epidural PCAs. We began the discussion with defining the scope of PIFT, which is mean to be intrafacility from acute care to acute care, and not for those going home or chronic care facility with their own devices. All the medical directors agreed that they had not considered the epidural as a route but are open to considering it. Agreement that it fits the realm of PIFT and that a module would need to be fit into the program to accommodate the training for this device since it is different enough from subcuaneous or intravenous PCA.	Motion by Liebow with second by Kendall and unanimous approval to add epidural PCA to the PIFT module and Batsie will create the addition.
5) Abdominal drains	Continuing on the issue of device questions, where do abdominal drains live in our protocols. These are devices that are low risk in transport and usually self-contained. Discussion around asking OLMC and discussing with sending clinician around trouble shooting, does this fit in PIFT, or can we create language to cover these low risk devices? Liebow and Busko and Dinerman will work to create such language and bring it back to us. Liebow did voice that he feels this is just an educational issue and LeBrun feels we need guidance around this area.	Liebow, Busko and Dinerman will create a paragraph to give us guidance that could be accepted as a directive around this area.

6) Xopenex	A change in available medicines may be occurring that may impact EMS providers and our choice of medications. Levalbuterol is currently being considered as the beta-agonist of choice by the State of Maine for patients that it covers and there is also a move to see if hospitals will follow suit. Xopenex is just being used as an example regarding medication equivalency-- some patients may only have this available to them and/or feel that this is the only medicine that helps them. This could impact helping patient with their meds or intrafacility transports. Busko noted that New York state has medication equivalency language in its protocols, but does this lend itself to much personal preference in drug box composition? Who should be able to OK equivalency type of substitions-- service medical director, regional medical director, state medical director?	This seemingly simple issue has layers of potential controversy-- will revisit as one of our annual goals.

7) PIFT	A) Discussed the request from Dr. Collamore regarding including a critical care technician from her area in the PIFT program. We discussed this last month as well and the group felt that the PIFT is meant for paramedics and is written towards that license level. Increasing the catchment group outside of paramedics is not envisioned at this time. (B) Report from Batsie that beta testing is being set-up and epidural PCA component will be added to the program; (C) Request by Liebow and Dinerman to include language for the paramedic to determine if any discontinuation or failure to initiate therapy has occurred by the paramedic's judgment when assessing the patient in the sending hospital. Much discussion around this topic including Marcolini asking what we are doing with this info; Smith stating that this is a hospital decision; LeBrun feeling this is best linked to local medical control in conjunction with the hospital, and LaHood echoing LeBrun. Liebow felt this is simply putting the patient first, and although no one disagreed with the sentiment, MEMS does not have purview over the interhospital workings. This would put the paramedics and MEMS in an untenable position.	A) Diaz will contact Collamore and explain the decision of the group; (B) No action-- this is the desired pathway; (C) No motion to carry this forward

8) OLMC	Busko presented that he and Sholl have worked out a program which is 1 to 1 1/2 hours in length. It has an introduction, overview of EMS, Overview of Medical Direction, and review of protocols. Questions on state structure and other queries to be sent to Diaz/Bradshaw and brought to next meeting. Much discussion about certification and what this means. This is an open book test and Smith concerned that certification would not fit well if the goal is to go through the material in some fashion and thus what does it matter if you pass or not. This is probably a difficult discussion to have since the program is not presented at this time. Per our last conversation, the pathway is beta test, and then to discuss with Maine ACEP and MHA if appropriate to get this as some standard, whatever that means. Dinerman noted that whatever path we take, we should avoid building cynicism into the system. Beals asked if this included midlevels, and Busko noted that the intent is to include midlevels and residents.	To bring full program to MDPB and then to entertain discussion of implementation and program completion/certification
9) CAC	3pm meeting today	All invited
10) MEMS QI	Last month's meeting abbreviated, no report	No action
11) Summer Schedule	Do we meet in July and August? Consensus to take one month off, and decided to take August off	Consensus action to take August off but reserve the right to call a special session if needed, and Diaz will work on pandemic flu for possible protocol and circulate via e-mail.